TABLE 1. THE MEDICAID POPULATION, BY CATEGORY OF ELIGIBILITY: PERSONS ELIGIBLE AT SOME TIME DURING FISCAL YEAR 1980

Category of Eligibility	Millions of Persons in Category
MANDATORY COVERAGE	
SSI Recipients	3.2
AFDC Recipients	14.0
Children in AFDC families	(9.3)
Adults in AFDC families	(4.7)
OPTIONAL COVERAGE	
Financially Eligible Children	6.3
Persons Eligible for But Not Receiving AFDC or SSI Assistance	3.0
Other[a]	2.1
TOTAL	28.6

SOURCE: CBO simulation of Medicaid eligibility. See Appendix A.

NOTES: Includes only noninstitutionalized Medicaid recipients (see Chapter I). Details may not add to totals because of rounding. Totals do not include estimates of those eligible under "medically needy" provisions.

a. Includes caretaker relatives of financially eligible children, recipients of only state supplemental payment for the SSI population, and persons who would be eligible for cash assistance if their states' AFDC programs included families with children deprived of support because of an unemployed parent.

RECIPIENTS OF SSI

Recipients of SSI, who make up 11 percent of those eligible for Medicaid, account for 30 percent of program expenditures. By mandating the inclusion of SSI recipients, the federal government exerts considerable control over Medicaid eligibility policy toward the aged, blind, and disabled. Under SSI, the federal government sets the income and assets criteria that such people must meet to qualify for cash assistance. In 1980, the federal income standard for a single person to qualify for SSI--and hence for Medicaid--was income of less than $238 per month.[2] About one-third of the states have been permitted to apply somewhat more stringent Medicaid eligibility criteria to SSI recipients.[3]

AFDC RECIPIENTS

Under the AFDC program, states establish income and assets criteria for the eligibility of single-parent families. Within guidelines established by the federal government, state monthly income criteria for AFDC ranged from $140 in Texas to $569 in Oregon in 1980. States also have the option of providing AFDC to families with an unemployed parent; in states where these families are eligible for AFDC, they must also be provided with Medicaid.

Although persons in AFDC families represented about half of the noninstitutional population eligible for Medicaid in 1980, only about one-fourth of Medicaid expenditures were made on behalf of members of AFDC families. The largest single group of people

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2. Most states provided a supplement to the federal SSI payment, and the federal rules permit states to grant eligibility to persons who receive SSI-state supplements but whose incomes disqualify them for federal SSI benefits.

3. When federal/state assistance programs for the aged, blind, and disabled became exclusively federal in 1974, states were permitted to use more restrictive standards than SSI, provided those standards were in effect before the enactment of SSI. At present, 15 states apply some type of limitation on Medicaid eligibility of SSI recipients. Many refer to these as "209(b) states," reflecting the section of the Social Security Act of 1972 which provided this option.

eligible for Medicaid consists of children in AFDC families, who make up one-third of the eligible population. Adults in AFDC families make up another 16 percent.

OTHER GROUPS DEEMED ELIGIBLE

Most states have chosen to include in their Medicaid programs one or more groups of people not required by federal law. In general, the optional groups that states voluntarily cover comprise low-income persons who do not receive cash assistance but who have the same demographic characteristics as those covered by AFDC or SSI; they are children and other members of families with dependent children, and aged, blind, or disabled people. About 6.3 million of the 11.5 million persons eligible in 1980 for optional Medicaid coverage were children in families that met the AFDC income and assets eligibility criteria of their states but not the other AFDC criteria. Examples include children in certain two-parent families, self-supporting children, and children in foster homes. Another 3.0 million people are eligible for Medicaid because they live in states that have chosen to grant eligibility to persons who qualify for but do not actually receive cash assistance. The other optional groups make up a relatively small proportion of the Medicaid recipient population.[4]

Many states have chosen to extend coverage to individuals and families with incomes above cash assistance levels by adding the "medically needy" to their Medicaid programs. Medically needy is defined as applying to anyone who meets all categorical requirements for Medicaid eligibility and whose income, after deducting medical expenses, is less than the state's medically needy income standard.[5] In 1979, the income standard for a family of four to

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4. These groups include recipients of emergency cash assistance; persons eligible for AFDC under the broadest interpretation of federal law; persons who would be eligible for AFDC except for failure to register for manpower training; disabled alcoholics and other addicts who refuse treatment required for SSI eligibility; and blind or otherwise disabled persons who refuse vocational rehabilitation services required for SSI eligibility.

5. In general, the medically needy income standard for a family of three or more may be no less than the state's (continued)

qualify as medically needy ranged from $2,400 in Tennessee to $6,600 in Hawaii. No reliable estimates of the size of the population eligible through coverage for the medically needy are available, but the number of people in the category eligible for Medicaid appears to be much larger than the number of actual recipients.[6]

ELIGIBILITY AND TARGETING ISSUES

The unevenness of Medicaid eligibility among the poor raises issues concerning the program's targeting. Medicaid's critics have suggested that the program's mix of criteria excludes many people with incomes similar to those of people who do qualify, even though those disqualified may be equally in need of financial aid for medical care. In addition, many who actually do qualify have incomes higher than those of some people who fail to meet other eligibility criteria.

Some observers have opposed the use of criteria other than income in determining Medicaid eligibility. In their view, health care is a basic necessity, and guaranteeing access to a minimum level of care for all low-income persons is justified. Otherwise,

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5. (continued) AFDC payment standard. For individuals and two persons, the medically needy income level must equal or exceed the highest payment standard used in any cash assistance program (including AFDC, SSI, or an approved state SSI supplement program). Income eligibility levels may not be greater than 133.3 percent of the highest amount that would be paid to a family of the same size under the state AFDC program.

6. Because Medicaid eligibility for the medically needy depends upon a family's medical expenses, as well as its income, attempts to estimate the number of persons eligible under this provision on a national basis have been unsuccessful. A 1974 study in Massachusetts found that of those who meet categorical and income criteria to qualify as medically needy, only a small portion--less than 20 percent--actually took advantage of Medicaid. See Urban Systems Research and Engineering, Evaluation of the Medicaid Spend-Down: The Spend-Down Participation Rate (February 15, 1976).

low-income persons might never get care they need, or they might experience extreme financial hardship in obtaining it. Accordingly, adherents to this view maintain that income ought to be the only criterion for Medicaid eligibility.

The Ineligible Poor

Medicaid fails to reach roughly half of all Americans with incomes below federal poverty standards--some 12 million people. Most of the so-called "ineligible poor" are those who do not fall into any of the specific groups identified as eligible in the law. The ineligible poor fall into three groups:

- People living in states that do not provide optional coverage for which they would qualify elsewhere;
- People, such as single individuals and childless couples, to whom the federal government denies Medicaid; and
- People disqualified on the basis of income only.

Among the ineligible poor, there is a larger proportion of working adults and a smaller proportion of children than there is in the eligible population. This pattern reflects Medicaid's origins in social welfare programs that were directed towards the so-called "deserving poor," particularly children, who were not held responsible for their economic status. About 50 percent of those eligible for Medicaid with incomes below federal poverty guidelines were not in the labor force in 1980, whereas only about 31 percent of the poor who were not eligible were not in the labor force. Also, more of the ineligible poor were employed full time in 1980 than were their eligible counterparts. Children constituted a much larger portion of the eligible poor (65 percent) than of the ineligible poor (36 percent). Table 2 presents a comparison of the eligible and ineligible poor grouped by demographic characteristics.

The Eligible Nonpoor

In 1980, about 16 million people with annual incomes above the federal poverty guidelines were eligible for Medicaid during some portion of the year. Some 5 million--one fifth of those

TABLE 2. BREAKDOWN OF DEMOGRAPHIC CHARACTERISTICS OF THE POOR POPULATION[a] ELIGIBLE AND INELIGIBLE FOR MEDICAID: FISCAL YEAR 1980, IN PERCENTS

Characteristics	Eligible	Ineligible
EMPLOYMENT STATUS		
Not in the Labor Force	50	31
Unemployed[a]	7	3
Employed Part-Time Only[b]	9	8
Employed Full-Time Only[b]	22	37
Employed Part and Full Time[b]	12	21
AGE AND SEX		
Under 21	65	36
Males Aged 21-64	4	23
Females Aged 21-64	22	30
65 and Over	10	11
RACE		
Nonwhite	41	23
White	59	77
FAMILY		
Members of Families Headed by Women	75	33
Members of Families Not Headed by Women	25	67

SOURCE: CBO Simulation of Eligibility.

a. Poverty as defined by U.S. Bureau of the Census.

b. Periods of unemployment and full- or part-time employment do not necessarily correspond to Medicaid eligibility periods.

eligible for Medicaid--were in families with annual incomes at least double the federal poverty standards (that is, higher than $16,900 in 1980). Persons with relatively high annual incomes may qualify for Medicaid because eligibility determinations are made on the basis of periods shorter than a year. For example, a family with little or no income during the first three months of 1980 but with earnings above $8,450 throughout the rest of the year might have qualified for Medicaid during the period with low income. Such a family would have been defined as nonpoor according to federal standards for 1980, but it would still have been eligible for Medicaid.

The composition of the Medicaid-eligible population with annual incomes in excess of twice the federal poverty standard also reflects the orientation of welfare on the young; about 70 percent of the members of these families were children. An additional 17 percent were adults in families with dependent children. In 1980, the eligible nonpoor population--Medicaid recipients with incomes above double the federal poverty level--was constituted as follows:

- 46 percent children in families that did not receive AFDC benefits but whose families met AFDC income eligibility criteria for at least a portion of a year;
- 23 percent children in families receiving AFDC benefits;
- 17 percent adults in families that received AFDC benefits;
- 9 percent blind and disabled; and
- 5 percent age 65 and over.

Most people with incomes higher than double the federal poverty level live in states with relatively high income eligibility standards for AFDC, and hence for Medicaid. Approximately 36 percent of such recipients reside either in California or New York.

CHAPTER III. BENEFITS, REIMBURSEMENTS, AND EFFECTS ON USE OF HEALTH CARE

Like eligibility, the benefits available under Medicaid, and the methods and rates of payment to providers of services, are determined by a mix of federal guidelines and state discretion. This chapter reviews the range of services that state Medicaid programs cover, either by law or by choice, as well as the various ways in which those services are paid for. The closing portion of the chapter recapitulates evidence of the program's effectiveness in increasing the use of health services by the poor and in improving their health.

BENEFITS

Federal law requires that states operating Medicaid programs offer participants a basic set of services. These include:

- Hospital services (both outpatient treatment, and for inpatients, room and board and ancillary services),
- Physicians' services,
- Diagnostic services (including radiological and other laboratory studies),
- Family planning consultation,
- Nursing home care in so-called "skilled nursing facilities,"[1] and
- Screening and treatment of children for various illnesses and impairments.

1. Care in "skilled nursing facilities" is more intensive than the care provided in "intermediate care facilities" that may be covered at state option.

Anyone eligible for Medicaid, regardless of his state of residence, is entitled by law to these basic services. Altogether, payment for mandated services accounted for 60 percent of all Medicaid outlays in 1978.

In addition, all states elect to provide other forms of care. Care in "intermediate care facilities" is available in all states with Medicaid programs; such care accounted for 17 percent of Medicaid expenditures. Another 6 percent went for prescribed drugs. Assorted other services that states chose to offer made up the remainder of Medicaid costs.[2]

Critics of Medicaid's current structure cite the program's broad range of benefits as one source of expenditures that should be curtailed. Altogether, the benefits mandated by federal law, together with those that states may choose to provide, constitute more extensive coverage than is available to the general population through private health insurance. For example, unlike insurance policies in the private sector, Medicaid covers nursing home care, and in many states dental care, eyeglasses, hearing aids, and prescription drugs are also provided. Also unlike most private health insurance, Medicaid reimburses preventive care for patients without symptoms.

On the other hand, Medicaid is not a health insurance plan, but rather a means of financing medical care for low-income persons. Services not usually found in insurance plans, such as routine dental care or prescription drugs, entail out-of-pocket expenses for private patients. Such services are excluded from most insurance plans for one of two reasons. Either the service is relatively predictable, such as routine dentistry, and its

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2. Other optional services may include: care given by other practitioners (such as podiatrists) within the scope of their licenses; home health care; private duty nursing; clinic services; dental care, including preventive; physical therapy and related services; other diagnostic, screening, preventive, and rehabilitative services; hospitalization for tuberculosis; hospitalization for mental disorders for patients 65 years or over; and psychiatric hospitalization for youths under 21 years.

inclusion in health insurance would not provide protection against unforeseen expenses; or the cost of administering some benefits, such as reimbursement for prescription drugs, is high relative to the cost of the service. Though it would not be efficient to include these benefits in health insurance, their exclusion from Medicaid might simply make them unavailable to low-income people.

In order to limit recipients' use of services and contain program costs, states may adopt limits on the use of some covered services or may impose cost sharing in some form. Some states impose a limit of, for example two weeks, on Medicaid patients' length of stay in a hospital. Other states limit the number of physician visits per month. Prior approval by the state Medicaid program for admission to a nursing home is required by many state programs. Cost sharing, usually in the form of shared payment (copayment) for prescription drugs, is required in 15 state Medicaid programs. But states cannot require coinsurance or deductibles for mandatory services, such as hospital and physicians' care, given to AFDC or SSI recipients.

REIMBURSEMENT

The reimbursement rates for services provided to Medicaid recipients are set by the states, within guidelines laid down by the federal government. As a result, there is wide state-to-state variation in how much providers are paid. Reimbursement of practitioners, such as physicians, is the area in which the guidelines give states the greatest flexibility. Hospital reimbursement levels are subject to much tighter control; and the states' choice of reimbursement methods is subject to approval by HHS.

The difference between Medicaid fees and Medicare fees for physicians' services is substantial, and the difference between Medicaid fees and those charged private patients is even greater. For example in 1975, Medicaid fees for specialists were only about 77 percent of the Medicare levels.[3] Though fewer data are available to compare Medicaid fees with fees charged private

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3. Ira Burney and others, "Geographic Variation in Physicians' Fees, Journal of the American Medical Association, September 22, 1978, vol. 240:1368.

payment patients, a 1976 survey found Medicaid's fee for a routine follow-up office visit to be 40 percent below physicians' usual fees.[4]

Medicaid reimbursements for physicians cannot exceed the federally established reimbursement levels for Medicare, but most states have set them lower. Under the Medicare physician fee profile, which sets a limit for Medicaid reimbursements in all states, physicians are paid the lowest of their actual charge, their average charge, or the 75th percentile of charges for the same procedure. This latter method is generally referred to as a system of "usual, customary, and reasonable" charges.

Under Medicaid, a state may set physician reimbursement levels in one of two ways: fee schedules or fee profiles. A fee schedule assigns a value for each medical procedure relative to some basic procedure. A price is assigned to the basic procedure and consequently to all other procedures. A physician fee profile, on the other hand, uses the distribution of charges for a particular procedure to set a maximum level, for example, at the 75th percentile. States using this approach generally compare the physician's actual charge against the level set by the profile and pay whichever amount is lower.

Hospitals are reimbursed according to the "reasonable cost" method used by the Medicare program for setting rates, unless the states receive approval from HHS to use an alternative method. Under the reasonable cost approach, hospital rates are determined on the basis of the average cost for treating Medicaid patients. This reimbursement method gives hospitals little incentive to minimize costs, however. (This and other cost factors are considered in greater detail in Chapter IV.)

MEDICAID'S EFFECT ON ACCESS TO MEDICAL CARE AND ON HEALTH STATUS

Since the implementation of Medicaid, the use of health-care services by the poor has increased noticeably, and the health of poor people appears to have improved somewhat. By some measures,

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4. Frank A. Sloan, Jerry Cromwell, and Janet Mitchell, Private Physicians and Public Programs (Lexington Books, 1978), and Jack Hadley, "Physician Participation in Medicaid: Evidence from California," in Health Services Research, Winter 1979.

Medicaid has contributed to this improvement, but the poor continue to experience higher levels of illness than the rest of the U.S. population. The goal of mainstream care for the poor (discussed in Chapter I) has not been fully realized.

Increased Use of Medical Care by the Poor

Poor people's use of physicians and hospital care has risen substantially since Medicaid began in 1966. Between 1963 and 1976, the proportion of low-income persons seeing a physician during the year rose 30 percent (see Table 3).[5] Hospitalizations rose 35 percent between 1964 and 1973, but the rate has changed little since then. In contrast, visits and hospitalizations among the nonpoor rose by 4 percent and 2 percent, respectively, during the same period.[6]

Some evidence indicates that, within the poor population, eligibility for Medicaid makes a difference in access to physician's care. In 1969, people who were eligible for Medicaid visited physicians 6.6 times, on average, compared with 4.7 visits for low-income persons not receiving public assistance.[7] A comparison of the use of health services by the poor in Baltimore

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5. Ronald Wilson and Elijah White, "Changes in Morbidity, Disability, and Utilization: Differential Between the Poor and Nonpoor; Data from the Health Interview Survey: 1964 and 1973," Medical Care, vol. xx, no. 8 (August 1977), and unpublished data for 1977 from the National Center for Health Statistics. Income levels used to define poverty are $3,000 for 1964, $6,000 for 1973, and $7,000 for 1976. Approximately 20 percent of the total U.S. population had incomes below these thresholds in the years surveyed.

6. In order to compare the effect of Medicaid upon use of medical care, years prior to the implementation of the program have been compared to years following implementation.

7. Most, but not all, of the public assistance recipients included in the survey were in categories eligible for Medicaid. See Karen Davis and Roger Reynolds, "The Impact of Medicare and Medicaid on Access to Medical Care," in Richard Rosett, editor, The Role of Health Insurance in the Health Services Sector, (National Bureau of Economic Research, 1976), p. 391.

TABLE 3. PERCENTAGE OF U.S. POPULATION SEEING A PHYSICIAN, BY INCOME CLASS: 1963, 1970, and 1976

Income Class	1963	1970	1976	Percent Increase 1963-1976
Low	56	65	73	30
Medium	64	67	75	17
High	71	71	79	11

SOURCE: Adapted from LuAnn Aday and others, Health Care in the U.S.: Equitable for Whom (Sage Publications 1980), p. 100.

NOTES: The low-income standards used in this table are somewhat higher than the Bureau of the Census poverty standards and do not vary with family size. They are less than $4,000 for 1963, less than $6,000 for 1970, and less than $8,000 for 1976. In each year, persons in the low-income classification represent approximately one-third of the families surveyed.

found that Medicaid recipients used medical care more frequently than poor persons who were not eligible. On average, they were also more likely to see a physician than persons in middle- and upper-income levels--but not more likely than persons with similar levels of illness. The use of preventive services by healthy Medicaid patients was somewhat higher than for healthy middle- and upper-income persons.[8]

8. David L. Rabin and Elizabeth Schach, "Medicaid, Morbidity and Physician Use," Medical Care, January 1975, vol. 13, no. 1, p. 68.

Health Status of the Poor and the Care They Receive

The overall level of health in the U.S. population appears to have improved since the 1960s, and low-income persons have probably shared in these gains. Medicaid has contributed to better health in at least one respect, but incomplete data do not permit more general conclusions about the program's effectiveness. Between 1964 and 1976, however, infant mortality rates--a measure often used as an index of health status in general--have decreased for both blacks and whites.[9] Medicaid appears to have played a part in this improvement. In states where benefits are provided to low-income women during their first pregnancies, the Medicaid program has lowered infant mortality. Infant mortality rates within the first four weeks of birth are somewhat more than one percent higher in states that do not provide Medicaid to low-income women during first pregnancies.[10]

Despite improved access to care, however, the health of the poor remains below the rest of the population's. In 1976, persons in families with incomes below $7,000 reported 96 percent more days of restricted activity than was average for persons with incomes above $7,000. Some of the observed differences may reflect reductions in income accompanying illness.

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9. Because infant mortality data are not available by family income, the infant mortality rate for blacks is often used as a proxy for the rate for low-income persons.

10. Jack Hadley, Assessing the Adequacy of Health Manpower Supply (Urban Institute, 1980), unpublished study. An earlier study found that Medicaid eligibility did not have a significant effect on infant mortality; however, that analysis divided into three groups those states in which Medicaid benefits are provided during first pregnancies, thus reducing the significance of the Medicaid variable. See Michael Grossman and Steven Jacobowitz, "Determinants of Variations in Infant Mortality Rates Among Counties of the United States: The Roles of Social Policies and Programs," paper presented at the World Congress on Health Economics, Leiden University, the Netherlands, September 8-11, 1980.

The care that Medicaid recipients get differs somewhat from mainstream medical care. In general, the quality of Medicaid services is not substandard,[11] although low quality persists in some medical practices treating large numbers of Medicaid patients. A small share of all practices care for a disproportionately large share of Medicaid patients, and these practices tend to have high volumes of Medicaid patients. In 1976, almost 60 percent of all Medicaid patients were cared for by practices in which Medicaid patients accounted for 30 percent of all patients.[12] Many physicians in these large Medicaid practices are foreign medical graduates, and relatively few are certified in a medical specialty.[13] No link between the credentials of physicians in such practices and low-quality care has been demonstrated, however.

Burdensome paperwork and comparatively low reimbursement rates may discourage many physicians from accepting Medicaid patients. Although three-quarters of all physicians responding to surveys indicate a willingness to take Medicaid patients, the fraction of those who regularly do so is much lower.[14] One study estimated that only about 40 percent of California's physicians treated 10 or more Medicaid patients during a three-month period.[15]

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11. For a discussion of the available evidence on the quality of care in the Medicaid program, see Avedis Donabedian, "Effects of Medicare and Medicaid on Access and Quality of Health Care," Public Health Reports, vol. 91, no. 4, pages 322-331.

12. On average, Medicaid patients represent 13 percent of the patients in a medical practice.

13. Janet B. Mitchell and Jerry Cromwell, "Medicaid Mills: Fact or Fiction," in Health Care Financing Review, Summer 1980, vol. 2, no. 1.

14. Sloan, Cromwell, and Mitchell, Private Physicians.

15. Hadley, "Physician Participation in Medicaid."

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CHAPTER IV. FACTORS AFFECTING MEDICAID EXPENDITURES

Four factors have contributed, at different times and to varying degrees, to the past decade's steep rise in Medicaid expenditures:

- o Eligibility,
- o Benefits,
- o Trends in the health-care sector, and
- o Reimbursement policies.

Federal and state Medicaid policies govern the effects that several of these components have on total program expenditures, but Medicaid's ability to influence trends in health-care prices and use of services is limited. With the exception of nursing home care--Medicaid pays about half of all national expenditures for nursing home care--Medicaid's purchases of services accounted for only small portions of the market for medical care: 6 percent of all expenditures for physicians' services, and 9 percent of all hospital expenditures.

In recent years, increases in Medicaid expenditures have been caused largely by increased use of some services, particularly nursing home care, and by rising medical care prices. In the early years of Medicaid, the growing number of people eligible for the program drove expenditures upward.

Except for the addition of care in intermediate care facilities in 1972 (see Chapter III), expansion of benefits has not been a major factor in rising Medicaid expenditures. In fact, if nursing home expenditures are disregarded, Medicaid expenditures per recipient have risen less rapidly than national per capita health-care expenditures--at an annual rate of 11 percent between 1973 and 1978, as compared to the national rate of 13 percent.

ELIGIBILITY

Although eligibility changes are not expected to cause higher expenditures in the future (unless standards are liberalized), the sizable number of people the program now serves is a cause of high Medicaid outlays.

The AFDC segment of the Medicaid population increased at an average annual rate of about 9 percent during the early 1970s, accounting for most of the increases in the number of people eligible for Medicaid during that period. The number of AFDC recipients reached a peak in 1976 of about 11.4 million. Liberalized AFDC eligibility standards and greater participation contributed to this growth.[1] Later in the 1970s, the number of aged, blind, and disabled people who qualified for Medicaid rose following implementation of federal national eligibility standards for SSI. The number of Medicaid recipients in 1982 could equal the maximum of 22.9 million reached in 1977 due to the rising AFDC caseload.[2] Following 1982, declines are expected in many of the categories of eligibility.

The number of AFDC and SSI recipients who are also eligible for Medicaid is projected to diminish somewhat over the next five years. After peaking again in 1982, the AFDC caseload will probably resume its earlier decline. The number of SSI recipients is also expected to decrease but not so quickly, because one group--the disabled who are eligible for SSI--is expected to increase slightly. Because disabled recipients have higher average expenses than other patients--the average Medicaid payment for them in 1978 was $1,600, compared to $920 for an aged recipient, and $580 for an adult in an AFDC family--their increasing numbers will offset some of the savings from there being fewer AFDC and SSI recipients.

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1. John Holahan, Financing Health Care for the Poor, Lexington Books, 1975, p. 28, and Karen Davis and Kathy Schoen, Health and the War on Poverty (Brookings Institution, 1979).

2. The estimates of numbers of recipients were made by the HHS.

BENEFITS

The broad range of services covered by Medicaid (see Chapter III) has certainly contributed to the program's high cost. With the exception of intermediate care facilities, a type of nursing home care added in 1972, benefit expansions have not been a significant cause of increases in Medicaid expenditures, because states have not greatly increased their provision of optional services during the last decade.[3] Although states have occasionally chosen to expand benefits, such as reimbursement for part or all of the cost of prescription drugs, these changes in optional services by individual states have not had a significant effect on federal costs. Indeed, some states withdrew some optional services during the 1970s.[4] For example, some states stopped covering dental care, and others have limited the benefit to children.

Since Medicaid was initiated, the federal government's list of mandatory services has grown only slightly. The most noteworthy change was the addition, in 1969, of screening and treatment services for children, but the expenses for screening have not been large--$52 million in 1979; the additional costs for treatment cannot be determined from existing data.

TRENDS IN THE PRIVATE MEDICAL CARE SECTOR

Because Medicaid purchases care from private-sector providers, the rising prices of medical services, as well as increasing use of care in the private sector, have driven up Medicaid expenditures for each recipient. For example, as the price of an average hospital admission rises, or as physicians tend to hospitalize their patients more often, Medicaid expenditures rise.

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3. The addition of intermediate care facilities to Medicaid's benefit package in 1972 was actually the transfer of a service that states had previously financed with federal assistance through another program.

4. The minor role of added services in higher expenditures may reflect general satisfaction among the states with their initial choice of optional services. On the other hand, the broad range of services allowed and the availability of unlimited matching funds may have led some states to provide generous benefits that they are now trimming to reduce costs.

Although determining precisely the extent to which medical care price increases have affected Medicaid expenditures is not possible, inflation in the medical sector was responsible for about two-thirds of the increased per capita expenditure for personal health care in the 1970s.[5] An example of this is the rise in rates for hospital room and board, caused partly by higher wages and partly by rising prices for medical supplies. Medicaid reimbursements have generally followed medical care prices, which rose at an average annual rate of about 8 percent during the past decade.

Medical care price inflation is projected to continue to be an important component of future growth in Medicaid expenditures. For the period 1982-1986, CBO expects average annual increases in medical care prices to exceed growth in the CPI.

The remaining increase in per capita personal health-care expenditures--about one-third--can be attributed to greater use of services and facilities. Increased use of care is attributable, in turn, to two factors: increases in services (such as hospital admission) provided to each recipient, and greater intensity of resources (including tests involving costly equipment) used in treatments.[6] Unfortunately, much of the increase in intensity is

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5. Directly estimating the effect of price increases on Medicaid is impossible because of the large share of program expenses that go for nursing home care. The medical care component of the Consumer Price Index (CPI) reflects a different combination of services from Medicaid's.

6. With respect to hospital care during the 1970s, both use of care and intensity increased. Hospital use, as measured by number of discharges per 1,000 population, rose from 154 in 1973 to 160 in 1978--a 4 percent increase. As an example of the intensity factor, national community hospital costs per adjusted admission rose between 1970 and 1978 at an average annual rate of 3.5 percentage points in excess of input price increases, with this residual presumably due to increased intensity of care. See, Mark S. Freeland, Gerard Anderson, and Carol Ellen Schendler, "National Hospital Input Price Index," Health Care Financing Review, Summer 1979, vol. 1, no. 1, page 41.

incorrectly registered as higher prices, because the medical care component of the Consumer Price Index cannot distinguish when changes in price are caused by changes in quality.

In large part because of increased use, long-term care accounts for a disproportionate share of the rise in Medicaid outlays. Nursing home care in particular is a major component of the increase; Medicaid is the primary source of payment for more than half of all nursing home patients. Between 1973 and 1978, Medicaid expenditures for nursing home care rose from $3 billion to $7.4 billion--a rise of 150 percent. Costs of other services, in contrast, increased in the same period by 90 percent--from $5.6 billion to $10.6 billion. Thus, the portion of all Medicaid outlays for nursing home care shifted from 35 to 42 percent.[7]

Though corroborating evidence is limited, the very existence of Medicaid may in part have caused this increase in the use of long-term care. A substantial increase in the rate of use of nursing homes occurred between 1963 and 1969, coinciding with the introduction of the program. In that period, the number of people over age 65 in nursing homes rose from 25 to 37 persons per 1,000, an increase of nearly 50 percent.

REIMBURSEMENT POLICIES

Federal reimbursement requirements limit the ability of states to contain Medicaid expenditures. In requiring states to reimburse hospitals according to Medicare's "reasonable cost" method (outlined in Chapter III), federal law effectively dictates

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7. Expenditures for one component of nursing home care, the care of retarded persons in intermediate care facilities, increased by more than 600 percent. It has been suggested that the shifting of state-sponsored patients to the federal/state Medicaid program has caused much of this increase in care for retarded persons.

   Perhaps it would be more useful to examine changes in per recipient expenditures for long-term care to determine the relative effects of rising prices and increased use, but program data are inadequate for this purpose.

that Medicaid's hospital spending roughly keep pace with general private-sector trends. Those states that seek to set hospital reimbursements using an alternative to the reasonable cost method encounter a slow approval process and ambiguous approval criteria. Thus, the potential of alternatives such as prospective rate setting, which would contribute to cost containment, has not been fully realized. Further, states cannot exclude high-cost providers (either physicians or hospitals) from program participation; nor can Medicaid purchase most supplies or services in volume at reduced rates.

States have lowered or maintained low reimbursements in areas, such as physicians' services, where federal law permits them significant discretion. Lower reimbursement for physicians has helped to restrain increases in per recipient expenditures.

THE DETERMINATION OF FEDERAL COSTS AS A PERCENTAGE OF STATE PROGRAM COSTS

The federal government contributes a formula-determined fraction--transferred in the form of a cash grant--of the cost of each state's Medicaid program.[8] The portion of program costs paid by the federal government is greater in states with lower per capita incomes. For 1982 and 1983, the fraction the federal government pays will range from a statutory minimum of 50 percent in 13 states to 77 percent in Mississippi.

Under this matching formula, federal Medicaid expenditures are determined by state Medicaid expenditures. Because the federal government pays a percentage of each state's Medicaid

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8. The federal share for each state is recalculated every two years and is used for a period of two fiscal years. The percentages that were calculated in fall 1980 will be used in fiscal years 1982 and 1983 (October 1, 1981 through September 30, 1983). The formula is:

$$\text{state share} = \frac{(45 \text{ percent})(\text{state per capita income})^2}{(\text{national per capita income})^2}$$

federal share = 100 percent - (state share).

costs on an open-ended basis, federal expenditures rise as state Medicaid costs increase. The assurance of an unlimited matching grant from the federal government has been criticized as not giving state Medicaid operators adequate incentive to reduce costs and as encouraging states to broaden eligibility and benefits.[9]

Although the nature of the federal subsidy may cause states to spend more on Medicaid than they otherwise would, evidence indicates that states nonetheless remain sensitive to rising costs. First, many states have not extended eligibility to all optional groups and some states with limited eligibility have relatively high matching rates. Second, during the 1974-1975 recession, and again in the last two years, states have made efforts to improve program administration, reduce unnecessary use of services, and provide medical benefits at the lowest costs available.[10] Until recently, states have avoided eligibility and large-scale benefit reductions; however, in order to satisfy balanced budget requirements, states now appear to be considering these approaches.

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9. A recent econometric study concluded that higher percentage matches by the federal government lead to higher state Medicaid spending, holding other factors constant. See Thomas E. Grannemann, "Reforming National Health Programs for the Poor," in Mark V. Pauly, editor, National Health Insurance: What Now, What Later, What Never? American Enterprise Institute for Public Policy Research, 1980, pp. 104-136.

10. Gretchen Engquist-Seidenberg and others, State Initiatives in Medicaid Cost Containment, Center for Policy Research, Office of Research Studies, National Governors' Association: Washington, D. C., 1980.

PART II. OPTIONS FOR MODIFYING MEDICAID

CHAPTER V. OVERVIEW OF OPTIONS

In debating the possible modifications of Medicaid, legislators, analysts, and other observers disagree about what the program's underlying problems are and what changes would constitute improvements. The state-to-state variation in eligibility criteria, for example, can be considered inequitable; from another perspective, it can be regarded as a proper and desirable reflection of different states' priorities and resources, and ultimately, of their autonomy.

In Medicaid, as in all other welfare programs, state-to-state variation is a matter of debate. Federal policy in many programs has been to encourage states to extend eligibility beyond minimal levels. As an incentive in some income-support programs, the federal government has agreed to finance part of the cost of including additional categories of persons, or of enriching benefits. As states respond differently to these incentives, variations result, ultimately shifting federal tax revenues from states with limited programs to states with broad programs.

In the context of fundamental difference in outlook, two generally conflicting issues have arisen: Should program modifications be tailored primarily to curb expenditures? Or should they be designed to raise the portion of persons with incomes below the federal poverty standard that is eligible for Medicaid? The options examined in the following four chapters can therefore be categorized according to which of these goals they would further. The following chapters present options that would modify Medicaid by

- Revising eligibility to retarget benefits,
- Trimming benefits,
- Adjusting reimbursement policies, and
- Modifying the federal role.

To reduce federal outlays for Medicaid--the objective of most Medicaid proposals now before the Congress--legislators could modify the program's eligibility, benefit, or reimbursement requirements; they could also change the method of calculating the federal grants for states' Medicaid programs. Most current proposals for constraining federal costs would affect services other than nursing home care, and most avoid direct tightening of eligibility criteria. Proposals for constraining federal outlays include limiting some covered services, charging recipients for part of the costs of treatment, and lowering the rates of reimbursements to providers. Savings could also be realized by withdrawing the eligibility of some people with relatively high incomes (see Chapter II). Federal costs could also be lowered by annually limiting federal Medicaid outlays.

Broadening Medicaid's coverage of the poor within a fixed or shrinking federal budget would require some retargeting of current expenditures to newly eligible persons. If eligibility were expanded for people below federal poverty standards, the now eligible nonpoor could be displaced from Medicaid rolls. Another course would be to trim the present benefit package. Similarly, reimbursements to providers could be lowered.

One option that goes quite far beyond those discussed in the following chapter is the provision of Medicaid vouchers.[1] Under such a system, recipients would be given vouchers with which they would purchase either health insurance policies or membership in prepaid health plans such as health maintenance organizations (HMOs). Participating insurers or health plans would be required to cover or provide the basic set of services mandated by federal law (see Chapter III). A recipient who chose an insurance policy or health plan that cost less than the value of a voucher would be given all or part of the difference in cash. Proponents do not

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1. Such a plan is embodied in the National Health Care Reform Act of 1981 (H.R. 850), introduced early in the 97th Congress by Representatives Richard Gephardt and David Stockman. The bill proposes vouchers for low-income persons but delays them until the fifth year of operation (1988) to allow for development of competitive health plans. CBO is currently studying vouchers for low-income persons as part of its analysis of the "pro-competitive" approach to health-care cost containment.

regard this as an immediately viable option but instead propose delay of vouchers for low-income persons until after more competitive health plans develop, in response to changes in tax law and in the Medicare program.

PLAN OF PART II

Chapter VI examines five possible incremental changes in eligibility:

- Mandating coverage of all children in low-income families,
- Mandating coverage of all the medically needy,
- Terminating certain optional eligibility categories,
- Requiring relatives to assume some financial responsibility for care provided to Medicaid recipients, and
- Requiring states to adopt minimum eligibility standards.

The changes in benefits examined in Chapter VII include:

- Requiring cost sharing, and
- Eliminating certain benefits.

A variety of changes in Medicaid reimbursement policies is discussed in Chapter VIII, including:

- Expanding competitive bidding,
- Stopping the reimbursement of hospitals on the basis of "reasonable costs,"
- Terminating the requirement that states must reimburse all certified providers selected by recipients, and
- Raising reimbursement rates for physicians.

Four options to modify the federal role in financing Medicaid are discussed in Chapter XIX:

- Imposing a ceiling on the amount of federal matching funds available to each state (this option has been proposed by the Administration),
- Reducing the minimum federal share of state Medicaid expenditures,
- Ending states' responsibility for program costs and administration, and
- Adding incentives for state program expansions.